ABOUT YOU

First Name ______________________ **Middle Name** ______________________

Last Name ______________________

Street Address ____

Line 2 ____

City ___________________________ **State** ____________ **Zip** _________________

Mobile Phone ____-____-_____ **Work Phone** ____-____-_____ **Home Phone** ____-____-_____

Email Address _______________________________

Date of Birth ____ / ____ / ________ **Gender** ☐ Male ☐ Female

Height _______'_______" **Weight** _______ **lbs**

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other

Number of Children ______________ **Spouse's Name** _______________________

EMERGENCY CONTACT INFORMATION

Name _______________________________

Phone ____-____-_____ **Relation to You** ______________________

REFERRAL INFORMATION

Referring Physician ______________________ **Contact Info** __________________

Referring Patient ______________________

Are You Working with an Attorney? ☐ Yes ☐ No

How Did You Hear About Us?

☐ Word of Mouth ☐ Advertisement ☐ Social Media ☐ Direct Marketing ☐ Internet

REASON FOR VISIT

What is the date of your scheduled appointment? ____ / ____ / ________

How long have you had this complaint?

- ☐ Less than 5 days (Acute)
- ☐ Between 5-30 days (Sub Acute)
- ☐ More than 30 days (Chronic)

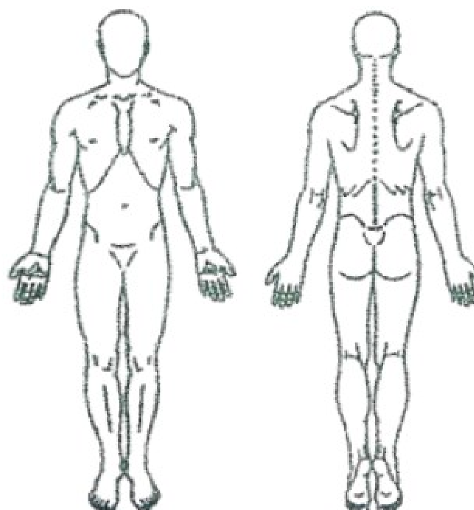
What caused this condition? ______________________________

What is the date this condition began? (Skip if due to accident) ____ / ____ / ________

What terms describe your discomfort best? (aching, burning, tingling, etc.) ______________________________

On the body diagrams to the right, please indicate your areas of symptoms by drawing in the appropriate symbols.

P - pain
N - numbness
W - weakness
S - shooting
A - aching



On a scale of 1 to 10, with 10 being the most severe, how would you rate your current level of discomfort?

None										*Unbearable*
0	1	2	3	4	5	6	7	8	9	10

How often do you feel this discomfort? ☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

How has this complaint changed since the onset? ☐ Worsened ☐ Remained the same ☐ Improved

What activity is most significantly affected by this discomfort? (Explain) ______________________________

____

What treatment have you received for this condition up to now? ______________________________

____

What aggravates this condition? ______________________________

What improves this condition or gives you relief? ______________________________

Have other health care provider(s) performed tests related to this condition? ______________________________

____

Have you ever had any previous episodes of this condition? ______________________________

____

CURRENT HEALTH

Other than the information already provided, do you have additional health concerns involving any of the following?

Muscles, Bones, or Joints	☐ No ☐ Yes	**Explain:** ____________
Nerves, Headaches, Dizziness, or Emotional	☐ No ☐ Yes	**Explain:** ____________
Head, Eyes, Ears, Nose or Throat	☐ No ☐ Yes	**Explain:** ____________
Heart, Blood Pressure, or Circulation	☐ No ☐ Yes	**Explain:** ____________
Shortness of Breath, Coughing, Asthma or Lung Condition	☐ No ☐ Yes	**Explain:** ____________
Stomach, Bowels or Digestive Conditions	☐ No ☐ Yes	**Explain:** ____________
Genital, Bladder, or Urinary Conditions	☐ No ☐ Yes	**Explain:** ____________
Diabetes, Thyroid or Glandular Conditions	☐ No ☐ Yes	**Explain:** ____________
Skin or Bleeding Conditions	☐ No ☐ Yes	**Explain:** ____________
Allergies or Sensitivities	☐ No ☐ Yes	**Explain:** ____________

PERSONAL AND FAMILY HISTORY

Have you had any surgical procedures?	☐ No ☐ Yes	**Explain:** ______________________
Are there any past illnesses or conditions we should be aware of?	☐ No ☐ Yes	**Explain:** ______________________
Do you have a past history of accidents or trauma?	☐ No ☐ Yes	**Explain:** ______________________
Are there any past illnesses or conditions we should be aware of?	☐ No ☐ Yes	**Explain:** ______________________
Are you presently taking any medication?	☐ No ☐ Yes	**Explain:** ______________________
Do you have a past family illness history, such as diabetes, cancer, hypertension, and progressive neurological diseases that we should be aware of?	☐ No ☐ Yes	**Explain:** ______________________

WORK AND SOCIAL HABITS

Current work habits: select all that apply

- ☐ Permanently fully disabled
- ☐ Permanently partially disabled
- ☐ Cannot work due to current condition
- ☐ Full-time (20-40+ hours/week)
- ☐ Part-time (1-19 hours/week)
- ☐ Retired ☐ Student ☐ Homemaker ☐ Unemployed

Personal social habits: select all that apply

- ☐ Smoke or use tobacco products
- ☐ Drink alcohol
- ☐ Drink caffeine
- ☐ Use recreational drugs
- ☐ Other, to be discussed with doctor

Present exercise habits: select all that apply

- ☐ No current exercises
- ☐ Exercise daily
- ☐ Exercise 3+ times per week
- ☐ Cannot return to exercise due to current condition

Diet and nutrition habits: select all that apply

- ☐ Vegan or vegetarian
- ☐ Daily supplements
- ☐ Other